RA13-035

June 24, 2013

U.S. Nuclear Regulatory Commission ATTN: Document Control Desk Washington, DC 20555-0001

LaSalle County Station, Unit 2

Facility Operating License No. NPF-18

NRC Docket No. 50-374

Subject: Licensee Event Report 2013-002-00 Manual Reactor Scram Following

Trip of Circulating Water Pumps

In accordance with 10 CFR 50.73(a)(2)(iv)(A), Exelon Generation Company (EGC), LLC, is submitting Licensee Event Report Number 2013-002-00 for LaSalle Unit 2.

There are no regulatory commitments in this letter. Should you have any questions concerning this report, please contact Mr. Guy V. Ford, Regulatory Assurance Manager, at (815) 415-2800.

Respectfully.

Harold T. Vinyard Plant Manager

LaSalle County Station

Enclosure: Licensee Event Report

cc: Regional Administrator – NRC Region III

NRC Senior Resident Inspector – LaSalle County Station

NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSION (10-2010)						1							10/31/2013	
LICENSEE EVENT REPORT (LER) (See reverse for required number of digits/characters for each block)							Estimated burden per response to comply with this mandatory collection request: 80 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the FOIA/Privacy Section (T-5 F53), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects.resource@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the information collection.							
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NRC FORM 366A

(10-2010)

LICENSEE EVENT REPORT (LER) U.S. NUCLEAR REGULATORY COMMISSION CONTINUATION SHEET

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LaSalle County Station, Unit 2	05000374	2013	- 002 -	00			ی

NARRATIVE

LaSalle County Station Unit 2 is a General Electric Company Boiling Water Reactor with 3546 Megawatts Rated Core Thermal Power.

A. CONDITION PRIOR TO EVENT:

Event Time: 2019 CDT Unit(s): 2 Event Date: April 25, 2013 Reactor Mode(s): 1 Mode(s) Name: Power Operation Power Level: 56%

B. DESCRIPTION OF EVENT:

On April 25, 2013, Unit 2 was in Mode 1 at approximately 56% power. The east condenser waterbox was being dewatered in order to address a condenser tube leak. Waterbox isolation valves 2CW007A and 2CW007C had been closed using their motor operators; however, in order to minimize leak-by, an attempt was made to manually seat the valves. These valves are 144 inch butterfly valves with no internal stops. Outlet isolation valve 2CW007C was seated without incident, but inlet valve 2CW007A was inadvertently moved past its closed position, which allowed flow from the running circulating water (CW)[KE] pumps to fill the waterbox.

At 2005 hours CDT, the Main Control Room was informed that a large amount of water was coming from the open waterbox upper manways. An attempt was made to close the manways; however, at 2019 hours, the 2A and 2B circulating water pumps tripped on high condenser pit water level, requiring Unit 2 to be manually scrammed. All control rods fully inserted.

The main steam isolation valves were manually closed, and reactor pressure and level control was maintained using safety relief valves and the Reactor Core Isolation Cooling (RCIC)[BN] system. At 2055 hours, the condenser waterbox manway covers were reinstalled and the condenser pit water level stabilized at approximately 12 inches.

This occurrence is reportable under 10 CFR 50.73(a)(2)(iv)(A) as an event which resulted in the manual actuation of the reactor protection system (RPS)[JC]. An ENS report was made to the NRC (EN# 48969) at 2123 hours CDT on April 25, 2013, pursuant to 10 CFR 50.72(b)(2)(iv)(B).

This event constitutes an unplanned scram with complications.

C. CAUSE OF EVENT:

The root causes of the event were determined to be a lack of strict procedural adherence on the part of the operators performing the waterbox dewatering task, and inadequate procedure quality. The operators were at the step in procedure LOP-CW-10, "Dewatering the Circulating Water System," where isolation valves 2CW007A/C are closed. They assumed that this step included manually seating the valves after closing them with the motor operators. However, manual seating is covered in Attachment B, "Waterbox Isolation Valve Adjustment Troubleshooting Guidelines," which includes a Caution to close the waterbox manways prior to manually manipulating the valves. Closing the manuarys would have prevented the event.

LOP-CW-10 did not include Cautions to close the manways prior to attempting to dewater in all of the applicable sections of the procedure. Additionally, the procedure only redirects to Attachment B when troubleshooting the failure of the waterbox level to decrease as expected.

NRC FORM 366A

(10-2010)

LICENSEE EVENT REPORT (LER) CONTINUATION SHEET

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NARRATIVE

D. SAFETY ANALYSIS:

The safety significance of this event was minimal. A reactor scram with a loss of the main condenser is an analyzed event. Reactor level and pressure control were maintained using RCIC and the safety relief valves. High pressure core spray was operable throughout the event.

E. CORRECTIVE ACTIONS:

- The personnel involved in the event were coached in accordance with Exelon processes.
- LOP-CW-10 will be revised to include Cautions in the forefront of the applicable sections to close the waterbox manways prior to attempting to dewater, and to clarify that Attachment B is to be used for any manual operation of the waterbox isolation valves.
- The waterbox isolation valve seats will be inspected and cleaned or replaced as required at the next Unit refueling outage.

F. PREVIOUS OCCURRENCES:

A search identified no previous occurrences within the past 10 years of a reactor scram caused by a condenser pit high water level trip of the CW pumps.

G. COMPONENT FAILURE DATA:

There were no component failures associated with this event.